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HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Delayed diagnosis of cancer due to missed histology results

1. This report discusses the care provided to Mr A by a private healthcare provider[1] at Mr A's local secondary-level public hospital. The Nationwide Health & Disability Advocacy Service referred a complaint to the Health and Disability Commissioner (HDC) regarding Mr A's concerns about a delay in the diagnosis of his prostate cancer due to inadequate follow-up of Mr A's histology results by private healthcare provider staff.[2] It is understood that histology results reported on 8 November 2021 (which were positive for prostate cancer) were not actioned until May 2022, due to a lack of understanding of a shared clinical information system.

Background

2. On 19 January 2016, Mr A underwent transurethral resection of the prostate[3] (TURP) and a catheter[4] insertion to relieve his lower urinary tract symptoms (LUTS). Histology samples taken from this surgery returned a benign (non-cancerous) result, and registered nurse (RN) B recorded that Mr A was made aware of this at a postoperative follow-up in March 2016. Mr A was then discharged back to his general practitioner (GP).

3. On 21 April 2021, Mr A was seen by a urologist at his local secondary-level public hospital, who noted elevated PSA[5] levels, some regrowth within Mr A's prostatic fossa,[6] and a very large bladder. The urologist placed a catheter to drain Mr A's bladder and placed him on the waiting list for repeat TURP surgery.

4. On 3 November 2021, a urologist, Dr C, performed repeat TURP surgery on Mr A at the local secondary-level public hospital. Dr C recorded that Mr A had irregular prostate anatomy and that she would send a prostate tissue sample for histology. Dr C's clinic letter to Mr A's GP noted that Mr A would be ready for discharge the next day and that a follow-up appointment would be arranged for the next month. However, the letter made no mention of the prostate tissue sent for histology. Mr A's GP confirmed to HDC that the practice did not receive a copy of the histology results.

5. Dr C told HDC that Mr A's irregular anatomy did not raise suspicion of malignancy, as it would have been due to the previous surgery. Despite this, Dr C sent a prostate histology sample

[1] A private urology practice that had been contracted to provide urology services to Health New Zealand | Te Whatu Ora as per its Health and Disability Service Agreement.
[2] All clinical staff mentioned in this report regarding Mr A's care were employed by the private healthcare provider, providing services under contract.
[3] Surgery to remove tissue from the prostate to treat urinary problems caused by an enlarged prostate.
[4] A flexible tube inserted in the body to deliver fluids into or withdraw fluids from the body.
[5] Abbreviation for prostate-specific antigen, a protein made by the prostate. A high PSA may indicate prostate cancer.
[6] A structure in the male pelvis situated beneath the bladder where the prostate gland rests.

as Mr A's PSA levels were 'heading towards the upper limit of normal for his age'. Dr C told HDC that she expected that the sample would trigger two points of review — first, a review by herself or her colleague, a urologist, Dr D,[7] and second, a further review at a postoperative nursing clinic (and a referral to a consultant clinic if the result was abnormal).

6. The histology report for Mr A's prostate sample was completed at a local laboratory on 8 November 2021 and recorded on the Éclair system[8] (accessed via a digital health system). The report noted that '[a]lmost all' of the sample showed an aggressive and fast-growing form of acinar adenocarcinoma.[9]

7. The digital health system is the clinical information system used by the tertiary hospital and local secondary-level public hospital to access patient medical records, with Éclair being a programme situated within the 'Clinical Applications' section of the digital health system. At the time of events, Dr C and Dr D worked across the tertiary hospital and the local secondary-level public hospital, whereas the registered nurses worked only at the local secondary-level public hospital.

8. Dr D reviewed the histology report at the tertiary hospital on 8 November 2021 and referred it on the same day to clinical nurse specialist RN E via the 'Referrals' component[10] within Éclair with the note: 'Can this man be seen in clinic urgently please. Needs PSA.' However, RN E did not see the histology results, and therefore she did not action Dr D's request. RN E told HDC that she did not action Dr D's request at the time as she was 'totally unaware' of the Referrals component within the Éclair system, as it was not used at the local secondary-level public hospital and was not included in any of the training sessions. Dr D told HDC that she was also unaware that nurses at the local secondary-level public hospital did not use the Referrals component of Éclair.

9. The private healthcare provider told HDC that instructions being sent via Éclair was a 'one-off' situation, as the usual communication method is via email or phone call. The private healthcare provider and Health New Zealand | Te Whatu Ora (Health NZ) accepted that there was a 'general unknowing' of this Referral component within Éclair and said that since the events there has been 'much more' awareness. The private healthcare provider also emphasised that the care provided was within Health NZ facilities, in coordination with Health NZ staff and using Health NZ IT systems.

10. In response to the provisional report, Health NZ told HDC that, although Health NZ is responsible for providing training on relevant systems for employees working at Health NZ sites, this includes only the basic functions of Éclair, and Health NZ in that area did not use the Referral component of the Éclair system at the time. Further, Health NZ told HDC that the outsourced urology service provided by the private healthcare provider was the only

[7] Dr D told HDC that, at the time of events, Dr D and Dr C had a job-sharing arrangement, where they signed off on each other's results if either was away or on leave.
[8] The private healthcare provider told HDC that the Éclair system holds all laboratory and radiology results and is accessed via a digital health system.
[9] A type of cancer that develops in gland cells.
[10] The private healthcare provider told HDC that the Referrals component is separate to the main patient results and can be utilised to convey instructions for treatment.

Health NZ service in that area that used the Referral component at the time, and the private healthcare provider did not advise Health NZ that it was using this component.

11. The audit trail for the histology report also shows that non-clinical staff viewed the report on 10 November 2021, 14 December 2021, and 16 and 19 January 2022, and that Dr D viewed and accepted the results on 23 November 2021. Health NZ did not provide HDC with an explanation on why the report was viewed on these dates.

12. On 9 November 2021, Mr A was seen by RN B at a postoperative follow-up clinic. RN B noted some concerns regarding urine flow and slight haematuria,[11] but there is no record of reviewing or discussing the findings of the histology report. Mr A attended multiple further clinics with RN E[12] and RN B[13] from November 2021 to January 2022, where catheterisation and urine flow were discussed, but again the histology report was not reviewed, followed up, or discussed.

13. The private healthcare provider's postoperative TURP nurse consultation checklist in place at the time of events provided that checking histology results is a part of the postoperative nurse consultation, and that triggers for a urologist review included any malignancy shown on histology reports.

Admission and diagnosis of prostate cancer — May 2022

14. On 20 May 2022, Mr A was admitted to a tertiary hospital with kidney failure, and on 21 May 2022, Mr A was diagnosed with locally advanced prostate cancer.[14] In her clinic note for this admission, Dr D recorded that histology results from the November 2021 TURP surgery showed the presence of cancer. A family meeting was held later that day, and the CT scan findings, missed diagnosis, and plans for treatment were discussed. Dr D provided an apology to Mr A and his family for the lapse in his care.

15. RN E told HDC that she became aware of the November 2021 referral only when she was notified of Mr A's diagnosis on 20 May 2022.

16. Health NZ told HDC that initial onboarding training is provided to all employees, ensuring that they can log in and navigate the 'basic functions' within the digital health system, but this training varies in relation to the need of the individual and the clinical role they occupy. The private healthcare provider told HDC that employees working at Health NZ sites are trained by the relevant hospital in any relevant systems, and the local secondary-level public hospital does not utilise the Éclair component within the digital health system, and therefore there was no training regarding this. The private healthcare provider said that this meant that Dr D's initial note to RN E was 'missed', as it used a system that was not used at Health NZ in that area.

[11] Blood in the urine.
[12] On 25 November 2021 and 3 May 2022.
[13] On 13 December 2021, 20 December 2021, 5 January 2022, 10 January 2022, and 24 January 2022.
[14] Treatment to suppress or block the production or action of male hormones.

Subsequent events

17. The private healthcare provider discussed this matter further in its nursing report and clinical meeting in May 2022, noting the lack of knowledge of the Referral component of Éclair as being the main cause of why and how the histology report was missed. In its letter to Health NZ dated 23 June 2022, the private healthcare provider noted that it is improving a process with the nursing team and consultants in that area to review all histology results from the area and refer via the digital health system, and it is updating its follow-up protocols.

18. On 5 September 2022, Health NZ completed a review into the events with RN E and RN B, which identified further issues with the digital health system. Review notes recorded that Éclair referrals within the digital health system 'vanish' from the main dashboard, limiting visibility of the request, and that often there is a double-up of notes within the digital health system and the private healthcare provider, which can be 'time consuming' to manage and work between.

19. The private healthcare provider told HDC that it is 'deeply sorry' for the errors that occurred regarding Mr A's diagnosis. It said that it continues to care for Mr A and has a 'very positive on-going relationship' with him. Dr D has since retired, and following this event RN B resigned and has not practised since.

Responses to provisional opinion

20. Mr A was provided with an opportunity to comment on the provisional opinion and confirmed that he had no further comments to make. He said that he is pleased that changes have been made to ensure that such events do not happen again.

21. The private healthcare provider was provided with an opportunity to comment on the provisional opinion. The private healthcare provider acknowledged that errors were made and that there is a good learning opportunity. Information received from the private healthcare provider has been included in this report where relevant.

22. Health NZ was provided with an opportunity to comment on the provisional opinion. Information received from Health NZ has been included in this report where relevant.

Opinion

Health NZ— breach

23. Histology results from Mr A's repeat TURP surgery reported on 8 November 2021 clearly indicated prostate cancer. Upon reviewing these results on the same day, Dr D added a note to the histology report for RN E that Mr A be referred for an urgent urology clinic review, but this was not actioned despite multiple follow-up clinics with urology nurses. Mr A's prostate cancer was not diagnosed until May 2022, six months after the histology results were initially reported. Information provided to HDC indicates that primarily this was because the report was recorded on a system unknown to the nurses at the local secondary-level public hospital, and therefore the report and associated note from Dr D were missed.

24. Health NZ and the private healthcare provider confirmed that Health NZ was responsible for providing training on relevant systems for any staff working at Health NZ sites. However, it

appears that the urology nurses at the local secondary-level public hospital did not receive such training regarding the Referrals component of Éclair. I accept Health NZ's statement that Health NZ in that area did not provide training on the Referral component of Éclair as it was not a component used by Health NZ in that area. However, I maintain my criticism that as the group provider controlling the use and access of Éclair by all staff in its workplace, Health NZ in that area held the ultimate responsibility to ensure that Éclair was used in the way it intended. Given that the Referrals component of Éclair could clearly be used by clinicians, Health NZ should have taken steps either to disable this feature (if not used) or at the very least clearly explain to all staff who used and accessed Éclair that this was not a component being used, to avoid confusion for clinicians (as occurred in this instance). Further, this component should have been monitored regularly given that it had not been disabled. This is supported by the changes made following the events.

25. Accordingly, I consider that there has been a clear failure by Health NZ in that area to train the private healthcare provider staff adequately on the relevant systems to fulfil their roles, and, failing that, to ensure preventative measures to avoid misuse of its hosted systems. Ultimately it was Health NZ in that area's role and responsibility to ensure that its clinicians were properly informed and trained in all appropriate systems, which in this case included the Éclair system within the digital health system for the private healthcare provider nurses.

26. I am also concerned that there is inconsistency between district hospitals on which systems are used for such referral requests, despite it being common for Health NZ in that area and Health NZ at a wider district level to send histology results to other district laboratories, and for patient care to be managed across different district hospitals.

27. In light of this information, I consider that Health NZ in Mr A's area breached Right 4(1)[15] of the Code of Health and Disability Services Consumers' Rights (the Code) for its lack of consistency in providing an appropriate level of training in relevant systems for all relevant staff, which directly contributed to a lack of cooperation between staff in delivering care to Mr A. This directly affected clinicians' ability to follow up and action critical results appropriately, leading to the delayed diagnosis of Mr A's prostate cancer and a lack of timely delivery of care for Mr A.

The private healthcare provider — educational comment

28. Although Health NZ in this area held the key responsibility for training the private healthcare provider staff appropriately on systems used at Health NZ sites, I consider that the private healthcare provider could have supported this more effectively by ensuring that its tools (such as the postoperative nurse checklist) were more comprehensive. The private healthcare provider is fully aware that often its staff work between and across different district hospitals, and therefore it is imperative to develop tools and processes that consider these contexts and ensure consistency of understanding across all staff.

29. I am concerned that, as the requesting clinician, Dr C did not follow up the histology report and associated request for referral adequately. It appears that this occurred because of an absence of shared understanding between the urologists and nurses on the systems used,

[15] Every consumer has the right to have services provided with reasonable care and skill.

which I consider is attributable to the lack of training provided by Health NZ, as noted above. Further, I consider that the lack of follow-up of the referral is mitigated by the fact that Dr C was in a job-sharing arrangement with Dr D (who appropriately referred the results on Dr C's behalf), and Dr C was unaware of the systems error attributable to Health NZ.

Changes made since events

30. Health NZ in Mr A's area told HDC that it reviewed its procedures and provided further education to the urology nurses, and now the same follow-up procedure is used by the tertiary hospital and the local secondary-level public hospital, and two other secondary-level hospitals nearby.

31. The private healthcare provider told HDC that it:

a) Developed a postoperative follow-up TURP protocol document to support the relevant nurse consultation checklist, including specific mention of the patient management systems to check for patient histology results; and

b) Developed a Regional Patient Management Framework for nursing staff, which includes a weekly 'sweep' of laboratory results to ensure that all histology results are reviewed, and an appropriate plan is in place for any abnormal results.

Recommendations and follow-up actions

32. I recommend that Health NZ in Mr A's area:

a) Provide a written apology to Mr A for the breach of the Code identified in this report. The apology is to be sent to HDC within three weeks of the date of this report.

b) Review the education/training being provided to the private healthcare provider staff in relation to the digital health systems and ensure that it includes all relevant systems across its partner districts (such as Health NZ in the wider district). As part of this review, ensure that the onboarding/induction process and checklist for all clinical staff (casual, contract, outsourced) includes specific mention of the relevant systems used by the hospital. Evidence of the review and education/training (such as the education/training material and staff attendance records) is to be sent to HDC within three months of the date of this report.

33. A copy of this report with details identifying the parties removed, except Health NZ, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Dr Vanessa Caldwell
Deputy Health and Disability Commissioner